



## **SUNRISE SUPPORT INTEGRATED SERVICES TERMS OF REFERENCE**

### **Purpose Statement**

The organizations listed below have developed an integrated process to deliver certain services in support of children, youth and their families through the Sunrise Support Center. While it may be possible to deliver these services independently, it is felt that they are more likely to be successful for children and their families if delivered in collaboration with each other.

The services that are offered through this approach include a variety of possible intervention services provided by one or more of the service providers, to be specified in each Family Action Plan and implemented accordingly.

### **Authority**

The membership in this integrated service has been determined to be appropriate and will operate in a manner that recognizes the value in delivering coordinated services in a collaborative fashion. Individually, the members derive their authority from the specific legislation that they operate under, or by virtue of being a program or activity of the governing organization in order to collect, use as well as to disclose client information to other integrated service providers on a need to know basis.

### **Participating Organizations**

Service providers may include:

Alberta Health Services: Addictions & Mental Health  
Alberta Child and Youth Services  
Family Supports for Children with Disabilities  
Alberta Solicitor General & Public Security

Parkland School Division No. 70  
RCMP  
Spruce Grove FCSS  
Stony Plain FCSS

Note: For details on the membership including authorities see individual membership data sheets.

### **Statement of Use**

Personal information that is collected by any of the above-described service providers will be used only for the purpose of providing counseling and intervention services. The focus of these services will be to assist the child and his/her family to reach goals as determined by the family in consultation with participating organizations.

Services will be delivered primarily by the integrated service providers. Where services need to be delivered by extended service providers, information will only be disclosed to them with consent. Information will not be used for any other purpose, unless required by law, and will only be disclosed to external parties with the consent of the individual to whom it pertains.

The services that are seen to be necessary will be identified through an assessment process that will build on the case or educational plans already in place. Where there is no such plan, one will be developed with the input of the child and their family. As part of the case plan, a case coordinator is provided. That person may serve as the main point of contact.

### **Records and Access**

Information that is collected by the member organizations will be maintained individually, other than the common registration and assessment form. That particular form will serve as the basis for the integrated services, and will be maintained by Parkland School Division No. 70 for a minimum of one year following the closure of the client file. Individual program records may be created and maintained by the partner organizations.

In order to obtain access to the records that relate to the integrated services, please contact the case manager assigned to your case (*alternative or specify position of the Parkland School Division No. 70*). This individual will refer you to those necessary agencies which may contain relevant information. Records that are held by the individual partners need to be accessed through their normal channels.



## CONSENT TO THE DISCLOSURE OF PERSONAL AND/OR HEALTH INFORMATION FOR THE PURPOSES OF INTEGRATED SERVICES DELIVERY

I, \_\_\_\_\_ (name) being the parent/legal guardian of \_\_\_\_\_ (name of student)  
authorize the disclosure of the following personal or health information:

\_\_\_\_\_ Psychological Assessments  
\_\_\_\_\_ School Records  
\_\_\_\_\_ Agency Services Information  
\_\_\_\_\_ Letters of suspension

\_\_\_\_\_ Alberta Health Services  
\_\_\_\_\_ Family Services for Children With Disabilities  
\_\_\_\_\_ Other (please specify) \_\_\_\_\_

to and between the service providers listed and initialed below:

\_\_\_\_\_ Alberta Health Services: Addictions  
\_\_\_\_\_ Alberta Child and Youth Services  
\_\_\_\_\_ Family Supports for Children with Disabilities  
\_\_\_\_\_ Parkland School Division No. 70

\_\_\_\_\_ Alberta Solicitor General & Public Security  
\_\_\_\_\_ Alberta Health Services: Mental Health  
\_\_\_\_\_ Other \_\_\_\_\_

(Please indicate your agreement for the sharing of information with any or all of the above described service providers by initialing those agencies to whom disclosure of your or your child's personal information may be made.)

for the following purpose(s): (The statement should include why the student is being referred and should be completed by referral source and/or parent.) \_\_\_\_\_  
\_\_\_\_\_

Sunrise Support Centre recognizes that the service needs of some children and youth are complex and cannot be easily addressed or delivered by a single human service organization in isolation of other service providers. Dealing with the overlapping issues concerning children and youth with complex needs requires a wrap-around team approach.

Formalization of an integrated case management model will be implemented for children and youth with complex needs so that various service providers involved in the child's life work together to address the child's and family's needs.

I understand that the overall purpose of the disclosure of this personal information is to allow the participating organizations to identify the needs of my child, the supports that may be necessary for my child and my family, and to coordinate and select the provision of services which will best meet the needs that are identified through the development of such short term and long term interventions as may be determined appropriate. I understand that in order to best service my child that this information may need to be shared amongst those service providers who are endeavouring to coordinate the services which will best meet the needs of my child and our family.

I acknowledge and agree that in order to best assess the needs of my child and my family, and the way in which the service providers may best address the same, that case management meetings may need to be held amongst the above identified service providers, in order to identify the needs of my child/family and to determine which services, if any, would benefit my child. I authorize the release of such information and documentation as is necessary between the service providers, that I have specified above, to assist in this purpose and the related coordination and provision of any such services decided upon by the community members, in conjunction with myself.

I understand that my consent is voluntary, and that failure to provide consent will not result in any adverse decision about my rights, benefits or services. However, if consent is not provided, I understand that my child's personal/health information will not be shared with the service providers for whom such consent is withheld and that these service providers may be unable to provide the services otherwise available.

I acknowledge that I have read the information on the reverse and understand that the service provider organizations listed on this form will be involved in the delivery of services to my child and our family as required. I also understand why I have been asked to disclose my individual identifying information, and that of my child, and have been informed of the risks or benefits of consenting, or refusing to consent to such disclosure. I further understand that I may revoke this consent at any time.

Dated and effective as of \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_

Expiry date: (if any) \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_

\_\_\_\_\_  
Client or Authorized Representatives' Signature (Student)

\_\_\_\_\_  
Client or Authorized Representative's Name (Parent or Guardian)

\_\_\_\_\_  
Source of Representative's Authority  
(Relationship to Student)

\_\_\_\_\_  
Witness Signature  
(Referral Source)

\_\_\_\_\_  
Witness Name – Please print  
(Referral Source)

☒ I consent to the sharing of information on an "as needed" basis to members of the Sunrise Team.